DOCUMENT RESUME

ED 234 571 EC 160 440

AUTHOR Jones, Mary Ann; Williams, Michael A.
TITLE Collaborative Wellness Counseling with a Group of Black Adolescents.
PUB DATE Jul 83
NOTE 26p.; Paper presented at the Council for Exceptional Children National Conference on the Exceptional Black Child (Atlanta, GA, July 24-27, 1983).
PUB TYPE Speeches/Conference Papers (150) -- Reports - Research/Technical (143)

EDRS PRICE MF01/PC02 Plus Postage.
DESCRIPTORS Adolescents; Black Youth; *Counseling Techniques; *Foster Children; *Group Therapy; *Holistic Approach; Self Concept

ABSTRACT

A counseling group for eight black male adolescents in foster care used techniques associated with wellness counseling and holistic health (emphasis on strengths, self responsibility, and a collaborative approach). The counseling program was a joint venture undertaken by two psychologists and a community mental health center. Games, fun activities, and popular music were incorporated into the program to help promote the participants' acceptance of the permanent separation from their natural families and to deal with conflicts arising from the separation. The group focused on the importance of individual responsibility in systematically identifying options for personal action and making intelligent choices. Positive results from the group included significant individual achievement for all members, positive group identification and good relationships with the therapists, increased openness in expressing individual needs, and greater appreciation of individual strengths. Among negative aspects were lack of involvement of foster parents and difficulties with billing and reimbursement. (CL)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

U.S. DEPARTMENT OF EDUCATION
NATIONAL INSTITUTE OF EDUCATION
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)
☑ This document has been reproduced as received from the person or organization originating it.
☐ Minor changes have been made to improve reproduction quality.
• Points of view or opinions stated in this document do not necessarily represent official NIE position or policy.

COLLABORATIVE WELLNESS COUNSELING WITH A GROUP OF BLACK ADOLESCENTS

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY
Michael A Williams
TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

Mary Ann Jones, Ph.D.
Michael A Williams, Ed.D.
Wright State University
College of Education & Human Services
Dayton, Ohio

ED234571

Introduction

This paper details the substance of a presentation made as part of the 1983 "National Conference and Training Workshops on the Exceptional Black Child," sponsored by the Council for Exceptional Children. The presentation and this paper were intended as a demonstration, via recapitulation, of the authors' collaboration with a major child welfare agency in a wellness counseling project which involved a group of exceptional Black male youths. The authors' discuss their views on what a holistic/wellness counseling therapy approach involves as well as the special appropriateness of this approach for working with and other largely non"mainstream" groups. A comprehensive description of the participants of these group experiences has been included.

The rationale for the focus on Black male adolescents through this approach, as well as for the criteria set and process used for their selection has been fully asserted. The authors also review their initial plans, their adaptive and innovative strategies and techniques, and their flexible mid-course adjustments. This paper also considers the outcomes of this project by reviewing observed behavioral trends, clinical impressions, and implications for replication. This paper and the presentation have been organized around five rhetorical ques-

EC160440

tions keyed to the title ("Collaborative Wellness Counseling With A Group of Black Male Adolescents"): (1) What is it; (2) How was it approached?; (3) How was it done?; (4) Who was involved?; and (5) What happened?

What Is It?

A popular focus of current research is that of the "holistic health" and/or "wellness counseling" movements which seek to describe a variety of novel and creative health care practices (Kopelman and Moskop, 1981; Hollen, 1981; Keller, 1981). Within this trend, health professionals endeavor to foster better total health (i.e., physical, mental, emotional, and spiritual) through redefining a traditional "sickness intervention" role and committing to a purposely coordinated and collaborative approach to health services that may involve screening, intervention, prevention and counseling using nontraditional therapeutic modalities, e.g., meditation, biofeedback, imagery, etc., (Bloomfield and Kory, 1978; Pelletier, 1979; Masi, 1978; Gawain, 1978).

Such was the impetus behind the establishment of the present experiment involving a cooperative effort between Childrens' Service social workers in Dayton Ohio and two Black psychologists. These professionals decided to develop and implement a counseling group -- for Black adolescent male youth, permanently in the custody of this children's agency -- which centered not on an historically sickness intervention model, but on a more proactive "wellness model."

Before detailing specific techniques employed in this venture, some discussion of the concepts of "wellness counseling" and "holistic health" seems warranted.* It is generally accepted that major assumptions underlying a "wellness" approach to mental health include (1) a focus on the positive (Kopelman and Moskop, 1981) bringing to light the strengths (and not the deficits) one may use to cope; (2) an emphasis on individual and personal responsibility for one's own health (Keller, 1981) i.e., establishing a more internal locus of control to handle life's problems; (3) a mental health provider redefinition of traditional authority role to that of teacher to encourage clientele to accept personal responsibility (Kopelman and Moskop, 1981) and (4) a collaborative approach (i.e., multi-disciplined) to address the multifacted issues that impinge on mental health (e.g., the behavior, social, economical causes). These assumptions underlay the intervention process employed within this group.

In implementing a "wellness counseling" method with non-"mainstream" individuals, it becomes necessary for mental health professionals to be enlightened about the pragmatic survivalism of such clientele. This concept specifically defined as

> "...a conceptualization symbolizing a pattern of health -- illness attitudes and behaviors that focus on the achievement and maintenance of low-level wellness in the most practical manner possible for the continuance of productive life" (O'Brien, 1982, p. 21).

While this quote addresses specifically physical health attitudes, it must be noted the judged "low level wellness" is a preconceived value

held by many professionals and must be reevaluated if the non-"mainstream" individual is to be treated holistically. What others may evaluate as "low level," within the appropriate sociocultural context, pragmatic survival may suggest a meaningful and adaptive adjustment.

The mental health professional must constantly attend to particular acultural attitudes and utilize them in a "wellness counseling" focus. Thus in treating the non-"mainstream" client, mental health care givers need to become familiar with culturally relevant values, priorities, and behaviors in order to establish the most meaningful plan of action.

How Was It Approached?

It was the authors' strong and earnest contention that good mental health practice is consistent with the features of holistic health care and wellness counseling, which are also especially suited to the target population of Black male adolescents. Prudent mental health practice must give priority emphasis to the maintenance of wellness and the prevention of illness, rather than the identification of disease and the pursuit of cure. Such an ideal can best be approximated by an objective, multicultural/pluralistic assessment of strengths and well as weaknesses, and by "accentuating the positive" through an enlistment of strengths in compensation and service of weaknesses. Such an orientation is absolutely essential to effecting true and, hopefully, lasting therapeutic impacts on Blacks and other largely non-"mainstream" groups.

Objective, multicultural/pluralistic assessment must supplant unsubstantiated and frequently negative assumptions. Mental health professionals and social welfare agencies have historically been designed and operated from a monolithic "mainstream" perspective. The greatest successes by these professionals and agencies have been realized mainly from working with mildly to moderately disturbed, middle to upper middle class, white Anglo=Saxon protestant individuals. Lerner (1972) documented that, since Freud, "the first psychotherapist," the field has developed and progress apace, yet at least one fact remained essentially unchanged. That fact is that "mainstream" individuals are more frequently viewed as mildly to moderately disturbed people, "good clients," who re generally easily accepted by and accepting of professional therapy and therapists. While, on the other hand, Blacks and other largely non-"mainstream" individuals are more frequently viewed as more severely disturbed people, "poor clients," who are generally rejected by and rejecting of professional therapy and therapists. According to Hopkins (1973) this situation is worse for the Black male: "Unless social service agencies discard their negative assumptions about the Black male ghetto resident, unsatisfactory relationships with these clients will continue (p. 53)." Lerner stated that:

> Freud, the first psychotherapist, was very clear about this fact, reiterating at frequent intervals that while his personality theory was all inclusive (multicultural/pluralistic), the method of treatment he derived from it was quite exclusive. He was equally clear, albeit regretful, about who was excluded...(p. 3)."

It is the authors of this paper's deep and strong conviction that the multicultural/pluralistic assessment perspective is far more effective, preferable, and ultimately therapeutic than the much more prevalent monolithic "mainstream" (a.k.a. "melting pot" (Amos, Jones, Williams, & Brooks, 1982) perspective. The multicultural/pluralistic perspective is all inclusive! It requires the acknowledgement, acceptance, and respect of all diversity possible within the human experience. If concerned with cultural and ethnic diversity, as well as the unlimited number of other possible types of diversity (e.g., age, handicapping conditions, regionalism, religion, sex, social class, etc.).

It is the diametric opposite of the monolithic "mainstream"/ "melting pot" view, which values assimilation, conformity, and homogenization of diversity and individuality in alleged guest for a common unity. The multicultural/pluralistic view might be likened to a tossed salad or vegetable stew, where each new and different ingredient only enhances the experience and where diversity and individuality are valued and preserved as well as the common unity which binds like the dressing on the salad or the gravy on the stew. Differences and individual uniquenesses are neither ignored nor overemphasized. Diversity is merely an acknowledged fact of life, with no implicit valuing. Difference is clearly no prima facie deficit!

When applied to the delivery of mental health and social welfare serviced, the multicultural/pluralistic approach fosters increased effectiveness due to its individually-oriented diagnostic/prescriptive

values which minimize the potential for prejudice and discrimination. A more personalized and individualized fact, with a minimum of fixed assumptions (positive or negative), is encouraged. Lerner (1972) and Hopkins (1973) have discussed the limited effectiveness of the other perspective when applied to mental health and social service delivery systems, especially with those individuals who are most extremely atypical and viewed as deviating most from accepted/expected "norm." The "melting pot" view is a clearly more inflexible, intolerant, and rigid system, which maximizes the probability of prejudice and discrimination.

In fact the Learning Triangle model for individualizing students' scholastic instruction (Hewitt, 1977), which has already been elaborated by Amos, et. al. (1982) to reflect the characteristics of students drawn from a multicultural/pluralistic society, can be further elaborated and extended to depict a scheme for the optimum delivery of mental health and social services.

Hewet's original formulation identified the three dimensions crucial to effective teaching and successful learning: (1) the curriculum or the activities, assignments, expectations, and instructional tasks; (2) the conditions or the circumstances and criteria established for the most complete and successful of the curricular goals and objectives; and (3) the consequences or the motivational incentives manipulated to assure the greatest probability that the curricular goals and objectives will be accomplished under the prescribed conditions. The adjustment or modification of this model that would better suit it for application to the fields of mental and social services would be the replacement of the term "curriculum" for consideration "service delivery orientation." "Service delivery orientation" would involve the

nature of the therapeutic activities, expectation, strategies, and tasks employed by the service provider.

As in Hewett's original formulation, each leg of this modified triangle must be adjusted to individual uniquenesses of each client if the most appropriate and effective therapeutic efforts and the most lasting therapeutic impacts are to be realized. The mental health and social service delivery systems must remain sensitive to existing multicultural/pluralistic reality. The basic goals and objectives for attaining maximum mental health and minimum quality of life experiences should remain fixed for all clients; the process for their attainment and the nature of their manifestation merely varies to accommodate and respect individual and multicultural/pluralistic differences.

How Was It Done?

This experiment and project was initiated when one of the therapists (Dr. Williams) was approached by the Director of the Clinical Services Unit of the Montgomery County Children's Services Board (C.S.B.) agency. Dr. Williams had recently established a consultant relationship with this unit of the agency and it was thought that he might be especially suited to provide group therapy experiences to some Black male adolescent boys. Black male adolescent boys were identified as targets of this therapeutic effort because the C.S.B. agency recognized, as Hopkins (1973) has pointed out, that it had difficulty in successfully responding to the needs of supporting Black

manhood. Dr. Williams was approached because his training and experiences reflected a combined clinical and educational orientation. He was also one of the few Black male clinical consultants available to the agency who might provide an additional therapeutic aspect of a positive adult Black male role model. The plan he formulated and proposed for ultimate implementation is detailed below in its entirety.

C. S. B. Adolescent Group Proposal

1. Consider Dr. Mary Ann Jones as possible alternative co-therapist to the other individual initially proposed.

2. Task invclves the establishment of:

   a. an adolescent therapy group (N = 6-8; ages 11-15 years; possibly co-ed, but definite male predominance); and

   b. concurrent parent group (comprised of adolescents' current foster parents).

3. Goals:

   a. to promote the adolescents' acceptance of the permanent nature of their separation from their natural families;

   b. to promote the adolescents' positive resolution of any conflicts and issues surrounding this permanent separation;

   c. to promote facilitation of the above through the coordinated collaboration of foster parents' efforts with those of the therapists; and

   d. to be approached by a combined activity group/behavior therapy/parent training orientation.

4. Process and stipulations for participant selection:

   a. C.S.B. caseworkers review cases to identify at least 12-15 possible adolescent candidates and foster parents (foster parent cooperation and participation is a critical issue in considering viability of any given candidate).

   b. Social summaries and the recommending caseworkers' brief written rationales submitted for each candidate.

c. Co-therapists and C.S.B. agency planners review case materials and rationale statements in order to prioritize list of candidates.

d. An orientation prior to group participation is crucial for adolescents and foster parents alike and may be done in any of several ways:

   1. unilaterally by caseworkers in individual sessions;

   2. unilaterally by therapists in individual sessions (probably most practical); and

   3. jointly by therapists and caseworker in individual sessions (most preferable but possibly creating some logistical problems).

e. Individual orientations could be done in 1-2 sessions (90-120 minutes), prior to group involvement, for the purposes of:

   1. exploring feelings and suitability re: group involvement;

   2. exploring current adolescent/foster parent perceptions of problems and issues;

   3. explaining general goals and nature of planned group experiences;

   4. formulating individualized goals for participation and identifying possible activity interests;

   5. conferring privately with each adolescent candidate;

   6. conferring privately with foster parents of each candidate; and

   7. conferring jointly with candidates and foster parents.

f. Adolescents and foster parents must recognize the critical importance of their willingness to cooperate and attend as regularly as possible (i.e., make a definite commitment to the whole process).

5. Proposed group meeting date and time:

   Thursdays 7:30-9:00 p.m.

6. Group meeting site possibilities:

a. C.S.B. offices on Merrimac Street;

b. Wherever sited, location must:

1. be conducive concurrent meetings (conducted separately as a rule, but jointly on occasion);

2. accommodate activity needs; and

3. provide facilities for snacks.

7. Target date to complete planning, selection, and orientation, and to start group sessions: October 7, 1982.

a. Group sessions will be conducted weekly thereafter, with the exception of November 25, 1982, Thanksgiving.

b. Group sessions will be concluded December 30, 1982.

c. Two individual therapist contacts will be held with adolescents and/or foster parents during course of group sessions (1st contact will occur the 3rd or 4th week and the 2nd will take place during the 7th or 8th week; individual sessions will be in addition to scheduled group sessions).

d. The final group session will be followed by an additional individual adolescent and/or foster parent summary session with the therapists.

8. Ongoing reports will be made as per routine C.S.B. monthly accounting, plus an additional written summary report, with recommendations for each adolescent/foster parent set.

9. Close collaboration and planning (before, during, and after summary reporting) is critical to the success of this venture. Co-therapist should hold weekly 2 hour planning and joint work sessions throughout the group life.

10. Payment of the therapists:

Therapists will be paid by a combination of the boys' medicaid benefits and C.S.B. agency general funds.

Following a series of pre-group planning and preparation activities (many of which have been detailed in the proposal), the group became a reality and scheduled its first session for November 4, 1982,

with things getting off to a slow and rather disappointing start. Only two boys and no foster parents were present of the six sets expected and planned for. Transportation arrangements were found to be the problem. A week later at the second session, all six boys were present, but only one foster parent showed up for the parent group. Transportation problems were apparently resolved, but there was strong evidence that the parent group component would not be attended.

The therapists were feeling considerable disappointment and frustration as they witnessed their very carefully and thoughtfully developed plan fizzle, plans which had received the unanimous verbal commitment and endorsement of the foster parents during the various pre-group orientation sessions. Determined to salvage as much as possible and gratified by the fact that they at least had all six boys, the therapists redesigned the plans to provide for their continued collaboration in direct contact with the boys. It was their intention to effect interactions and relationships between themselves and among the boys which reflected symbolic and surrogate "mother/father," "mother/son," and "father/son" qualities. There was, however, one unexpected bright spot inasmuch as, after this one session with full attendance by the boys, one boy requested permission to invite his roommate from a group home situation to join our group at its next session. It was a most ambivalent beginning, which saw no success with the foster parent component, but apparently very positive prospects with the boys alone.

The life of this group experience involved weekly sessions from November 4, 1982 through March 10, 1983, with the group meeting faithfully each Thursday evening during this period except Thanksgiving (November 25, 1982). During the early sessions, much effort, energy, and time was devoted to the establishment of rapport, group cohesiveness, and ground rules for smooth, orderly group functioning. Games, fun activities, and popular music, along with "junk food" snacks were used as effective tools for achieving these points. While games, fun activities, and popular music were used heavily, these were carefully selected to related, at least indirectly, to the basic goals and issues that this group experience was originally intended to address. Games like "The Game of Life," "Payday," "Careers," "The Ungame" and others were used. Music already known by and popular with these boys and Black youths generally was also a most valuable therapeutic tool (i.e., "rap" and soul music and songs such as "The Message," "1999," "Nobody Can Be You But You," etc.).

Later sessions saw the group activities evenly divided between task-oriented group counseling and "fun" activities. Topical issues became the focus of individual sessions, with the therapists leading the group through discussions on issues related to values, clarification, sexual awareness and responsibility, home and immediate living circumstances, independence and their future lives, and areas of needed self-improvement. The issue of identifying areas of needed self-improvement became the most important and climaxing focus of this group. Individual responsibility behavior was stressed as an absolute

necessity, along with the critical importance of systematically identifying options for personal action and intelligently making choices.

Final group sessions focused more on each boy's self-identification of some area of his life or behavior needing improvement and commitment to such efforts on a contingency incentive basis. Incentives used on such a contingent basis included the possibility of convincing C.S.B. agency administrators to once again extend the group life beyond the planned March 10, 1083 termination date; the therapists' willingness to purchase arrowhead pendants similar to one worn by Dr. Williams for each boy; and, most important, an acknowledged demonstration of their own capacity for self-direction and self-determination, even amid the constrictions and uncertainties of their foster child status.

Throughout the group life, the therapists met periodically with C.S.B. agency administrators and caseworkers in order to process review events and developments, as was coordinate this experiment and project for maximum success. This collaborative relationship and the climatic group focus on self-direction and self-determined was the basis for being able to conclude formal group sessions without atrophy and regression of the areas of noted growth and improvement. Each boy was expected to negotiate a service agreement with his caseworker which detailed his plans for continued efforts at self-improvement. Each boy's plan was to clearly specify the target behavior, include a statement that would be used as acceptable evidence of progress, and procedures for monitoring by their caseworkers. Even though the group

formally ended March 10, 1983, it was agreed that as an incentive to each boy's most diligent compliance with their negotiated service agreement, a reunion of the group would be held with the original therapists and all participating boys May 25, 1983. This reunion was held as scheduled and it was most gratifying to see that all boys were continuing to make good progress, gaining steadily in their capacities for self-direction, self-determination, and responsibility behavior.

Who Was Involved?

Eight Black adolescent youth between the ages of 12 and 15 were selected by CSB personnel for participation in the group. Each youngster was in the custody of CSB and had little or no hope of being reunited with biological family.

A description of each participant follows.

Jack,* an attractive 15 year old, who had been in the custody of CSB since he was 3, joined the group on the recommendation of another group participant. He had a history of several foster home placements and resided in a local group home at the time of group life. He was the most traditionally group ready participant having had prior group experience. Pre-group assessment did not occur, because of his unusual admission to group. He reported normal adolescent concerns of physical appearance, dress, music and interactions with girls, and a special interest in drawing. His contribution to group was as a role model through self-disclosing during discussion and exemplifying receptive and nonjudgmental group behaviors.

David, an active 13 year old, had had the most stable (8 years) foster placement of any group participant. He remembered little of his alcoholic mother, but was periodically in contact with his three biological siblings. Pre-group assessment suggested that David was highly distractible in school and often in trouble with school authority. He sought adult attention through acting out and evidenced some typical teenaged concerns. He expressed interest in popular sports (e.g., baseball, basketball, football, etc.). He seemed to demonstrate a good bit of emotional and behavioral maturity through group as indicated by the level of group trust and involvement displayed during its existence. He appeared to take what was discussed and evaluate its impact for his own life and behavior.

John, the youngest group member at 12, was the older son of a neglectful, alcoholic and violently abusive mother. He'd been in CSB custody for a period of two years and was in the process of being moved from one foster home to another at the onset of group. John's school work was reported as poor and was thought to be the result of emotional turmoil in his life. He sought adult attention and approval through helpless and acting out behaviors. He has a tendency to fabricate tales about being a gang leader. Pre-group assessment suggested a high level of anxiety and personal insecurity. He reported wanting money for a house, a fancy sports car, etc. as an adult -- remarkably normal pursuits considering the trauma of his history. John "hung in there" and established himself as a worthy peer, earning the respect of other group members. Initially reticent in group

interaction, toward the end of group he volunteered enthusiastically in group discussion.

Douglas, a large, well built 14 year old, had a history of sexual abuse, and runaway and delinquent behaviors. He'd been bounced back and forth between abusive, neglectful, drug dependent mother and an uncaring, rigid father. At the beginning of the group, he resided in the same local group home as Jack. Pre-assessment of Douglas indicated that he was manipulative, quick tempered, and resentful of authority figures. Douglas evidenced a great deal of anger, frustration and strong aggressive impulses. Initially Douglas was the most reticent member in the group. He became more active and verbal as group progressed, being the most vocal in expressing his displeasure about group termination. He learned less antagonistic means of interacting with authority figures and grew in his ability to respond to personally sensitive issues of his life without being openly hostile.

It was because of Jeff's poor adjustment to foster home placement that the group was formed. Jeff's history was vague but it appears that there was some neglect, if not active abuse, in his background. A grandmother had been his principle foster care provider until her health began to fail and she subsequently died. Jeff was living in what appeared to be an ideal foster placement, but remained emotionally aloof and continually emphasized his foster status. Jeff was obsessed with the desire to return to the custody of his biological mother and during the initial sessions was reunited with her. Subsequent to his reunion with his mother, his membership in the group was made inactive.

Damon, an orthopedically handicapped young man, resided in a geriatric residential facility and had been in CSB custody due to apparent neglect. He was paraplegic and developmentally immature in expressive language and age appropriate behaviors. Pre-assessment results indicated feelings of personal inadequacy, insecurity and inferiority. Normal adolescent concerns with sexual issues were noted. A healthy range of interests and activities were apparent. Damon learned to express himself and was challenged/expected to involve himself verbally in group discussion. He made significant progress in developing the ability to be expressive at his own initiative and in response to others.

Jeremy, a good looking, rather cocky 15 year old, had a biological mother who was violently abusive. He was the eldest of three boys, one being so severely abused as to require institutionalization. Pre-assessment data indicated that Jeremy was independent and aloof. He was active, outgoing, intelligent, and artistically talented. A local private agency had just assumed control of Jeremy's case at the outset of group. Some initial reluctance on the new agency's part had to be resolved before his inclusion within the group. Jeremy had normal, healthy, adolescent interests and he also displayed a social sensitivity and precocity. He had a positive school attitude and performed well academically. Concurrent with group participation, Jeremy was experiencing escalating and urgent adjustment problems in his foster home. The adjustment became so bad that Jeremy spent 2 weeks in juvenile detention when he returned to the group, he shared the exper-

iences with the other group members with very positive impact. But, before (and subsequent to) this event's occurrence, Jeremy assumed a strong leadership role with a generally positive influence.

Donald, last but not least, was a street wise, chameleon type young man of 15 years. He apparently was an abused youngster and had been in a series of foster home placements because of runaway, stealing and other behavior problems. At the time of group beginning, however, he was apparently adjusting quite well in his current foster care placement. He had been in a previous group experience and had been highly motivated to continue participation. He was described as warm, caring and compliant. His relationships with peers, teachers, friends appeared manipulative, but good. His interests included music and bike riding. During group, Donald was always willing to participate and became more mature in his expression as group progressed. He shared good "common sense" solutions to other members' problems despite a rather limited intelligence.

*The names have been changed.

What Happened?

At part of a formal report summarizing the whole project and experiment from start to finish, the authors and therapists formulated the following conclusions, which are listed separately as clusters of positive and negative points. While these thoughts have been organized into clusters of positives and negatives, the positives clearly out number the negatives and no other ordering or prioritization was implied nor intended.

Positives

1. There was a notable and significant amount of individual improvement and progress for all boys remaining the group until its conclusion.

2. The boys consistently exhibited a most disarming and humbling honesty in their dealings with the therapists.

3. All boys displayed a positive group identification and bonding, as well as good relationships with both therapists.

4. The male/female co-therapist arrangement and the use of contingencies in behavioral format proved to be most effective strategies.

5. All boys showed greater self-awareness and greater willingness to be responsibly self-directing.

6. Each boy became more appropriately open in the expression of his individual needs and more appreciative of his individual strengths.

7. The use of non-traditional techniques, such as popular, youthful music and activities, effectively served a dual purpose of promoting therapy as well as fun.

8. As the group progressed, the boys displayed greater and greater capacity and willingness to make a smoother transition from the discussion made (with greater and more consistent observance of the ground rules) to the activity/fun mode.

9. The group setting and physical facilities were excellent.

10. A number of the caseworkers were "troopers," going consistently "above and beyond the call of duty" to make this group possible and successful.

11. The Director of the C.S.B. Clinical Services Unit, was extremely supportive and willing to clear resistance and resolve problems.

12. The C.S.B. agency office night staff, switchboard operator and security personnel, were most congenial and helpful.

Negatives

1. Foster parent nonparticipation was disappointing and effectiveness limiting.

2. Time and energy investment by the therapists required more than was "legally" reimbursable by the C.S.B. agency and the Ohio Department of Public Welfare.

3. Communication and coordination between therapists and caseworkers was difficult and inconsistent, especially with those involved with Family Services.

4. The 45 minutes of discussion and 45 minutes of activity/fun split of each group session often was abrupt, with incomplete closure; transition was not as smooth as desired by therapists, possibly reflecting artifact of the discrepancy between traditional vs. non-traditional therapeutic styles and expectations.

5. Therapists would have liked more control over and input into when and how the group ended; all discussions seemed to be very heavily influenced by financial considerations by administrators and not as much by therapeutic factors. Not enough time was allowed to most comfortably and most therapeutically end the group.

6. An afternoon rather than evening meeting time would have been preferable; and the access to and availability of activity resources (i.e., games, films, etc.) was not facilitated by the C.S.B. agency.

7. By far the most irritating factor related to billing and reimbursement. The C.S.B. agency and the O.D.P.W. billing/payment mechanisms were atrociously ambiguous, inconsistent, and slow. These procedures required the maintenance of three sets of accounting and billing records. Rates of payment are low, below "usual customary rates," while performance demands and timeline compliance expectations most incompatibly high.

In addition to the above listings of positive and negative conclusions, the authors made some more general deductions. First, the concept and process of collaboration as an essential factor to an effective therapeutic effort was reaffirmed. Fruitful collaboration was realized at four levels: (1) the co-therapist relationship between two private practitioners; (2) the relationship between private practitioners and a major public social service agency; (3) the interdisciplinary psychological/social worker interaction; and (4) interagency contacts between private and public social service agencies. While the ultimate collaboration for this project (the child/foster parent/therapists/social worker/agency team relationship) was not fully realized, these authors still recognize it as a yet very desirable and obtainable ideal.

Secondly, even though these authors and therapists embarked upon this venture relatively free from the negative assumptions and prognoses for many of the boys included individually and the group as a whole, they were still taught and reinforced in the continual need to remain vigilant to resist the strong pull towards such traditional leanings. The analogy of the nurtured plant well illustrates this point. Consider the unfortunate house plants with a withered, barely viable appearance, the therapists approached each boy and the group with the idea of "watering and nurturing; despite little visible bases predicting recovery and blossoming. However, with a positive expectation tantamount to faith, "watering and nurturing" was continued which happily paid off in "blossoms and fruitage."

Positive expectations played a most significant role in this whole experience and importantly fashioned the outcomes. The therapists had confidence in their own knowledge and skills as well as the positive expectation that they could be called on to produce some positive (therapeutic) impact in their efforts toward each individual boy and the group as a whole. Similarly, positive expectations were consistently and firmly communicated, by both word and action, to the boys (clients), social workers, and agency from the therapists regarding roles and functions which might contribute to the beneficial and successful outcomes. Positives expectation is central to the holistic/wellness orientation employed as the primary clinical approach. The holistic/wellness orientation is most compatible and consistent with the adaptive, eclectic, and flexible demands of a multicultural/pluralistic client population as well.

Bibliography

Amos, O., Jones, M. A., Williams, M., and Brooks, D. Teaching in a Multicultural/Pluralistic Society. Lexington, Massachusetts: Ginn Custom Publishing, 1982.

Bloomfield, H. and Kory, R. The Holistic Way to Health and Happiness. New York: Simon and Schuster, 1978.

Gawain. S., "Creative Visualization," The Holistic Health Handbook (D. B. Ardell, Editor). Berkeley, California: And/or Press, 1978, pp. 374-377.

Hallen, P., "A Holistic Model of Individual and Family Health Based on a Continuum of Choice," Advances in Nursing Sciences, July, 1981, pp. 27-42.

Hewett, F. with Forness, S. Education of Exceptional Learners (Second Edition). Boston: Allyn and Bacon, Inc., 1977, pp. 365-377.

Hopkins. T. J., "The Role of the Agency in Supporting Black Manhood," Social Work, January, 1973, pp. 53-58.

Keller, M., "Toward a Definition of Health," Advances in Nursing Sciences, October, 1981, pp. 43-64.

Kopelman, L. and Moskop, J., The Holistic Health Movement: A Survey and Critique," The Journal of Medicine and Philosophy, vol. 6, 1981, pp. 209-235.

Lazarus, P. J., "Counseling the Native American Child: A Question of Values," Elementary School Guidance and Counseling, December, 1982, pp. 83-87.

Lerner, B. Therapy in the Ghetto. Baltimore, Maryland: The John Hopkins University Press, 1972.

Masi, A. T., "A Holistic Concept of Health and Disease," Journal of Chronic Disease, vol. 31, 1978, pp. 563-572.

O'Brien, M. E., "Pragmatic Survivalism: Behavior Patterns Affecting Low-Level Wellness Among Minority Group Members," Advances in Nursing Sciences, April, 1982, pp. 13-26.

Pelletier, K. R. Holistic Medicine. New York: Dela Coret Press, 1974.